Feeling blue, sad, or depressed:

how to manage these patients

Many patients present to primary care complaining of feeling blue, sad, or depressed. GPs generally work from a biomedical standpoint using the concept of depression, with medicalisation being the logical result. We believe that GPs are able to adopt a more person-focused approach in which they prioritise the psychosocial above the biological. Here we provide two examples of how GPs could start with this approach in a consultation with a patient who is feeling blue, sad, or depressed. An important element of the proposed approach is only applying a psychiatric diagnosis in selected patients with a high prior chance of serious psychiatric disorder.

THE BIOMEDICAL APPROACH

The high prescription rates for antidepressants[1] suggest that GPs work from a biomedical point of view and start questioning the patient about the symptoms of depression listed in the guidelines. GPs commonly report having 'no other option' than to prescribe given that patients are unable to access talking therapies quickly, and/or because of insufficient time for alternative approaches. Do GPs have other options? Yes!

THE PERSON-FOCUSED APPROACH

GPs can turn the biopsychosocial consultation model around — replace a disease-focused with a person-focused approach — and prioritise the psychosocial above the biological (flipped consultation).

The person-focused approach considers the presentation of distress as an invitation for a conversation about the individual's capacity to find solutions and resources from within their own context, empowering rather than medicalising an individual in distress. The person-focused approach follows a flipped order: it starts with psychosocial and only if necessary adds the biological.[2] How to start with the psychosocial? There are two possibilities.

TALK TO YOUR PATIENT

The first is co-constructing an explanation of illness with your patient. You say to your sad patient that such feelings are often the consequence of something happening in their life, and invite them to reflect with you on that idea. Mr Tomes (pseudonym) complained of feeling sad. While discussing some minor problems he suddenly said: *'Doc, how is it possible that I'm so sad?'* I replied that many people feel sad because of things that happen in their life, currently or in the past, and asked him what he thought about this. He started to cry and told me a story about a significant life event that he had been keeping to himself. After that he seemed relieved.

"GPs can turn the biopsychosocial consultation model around — replace a disease-focused with a person-focused approach — and prioritise the psychosocial above the biological ..."

The second is inviting the patient to tell their story. Barbara Hunter (pseudonym), who has recently moved into the area, consulted me, saying *'I'm depressed, I need medication.'* I said that I couldn't prescribe her antidepressants immediately as I would first like to know her better and get an idea about what was going on. I invited her for some consultations. We talked about her personal circumstances and what bothered her, about problems in the relationship with her husband emerging after they had discovered that their son had an alcohol addiction, and finally about their daughter who had revealed that her brother had sexually abused her.

Barbara said that she used to walk a lot, but lost the energy to do so. I said that I understood her feeling of being depressed. Together we decided that instead of starting antidepressants she would make another appointment, try to walk for an hour each day, think about how she and her husband used to discuss problems in the past, and consider if there were other problems contributing to the situation.

SYMPTOMS OF A PROBLEM NOT A DISEASE

What we do here is approach symptoms as potential indications of something being wrong rather than a sign of disease.[3] By helping patients understand their symptoms, the focus is on enhancing the autonomy and potential of the patient to recover. We think that exploring this should lead to a common description of the problem and that the patient feels that the GP shares their goals.[4] When a more structured approach is needed, working according to the Strengths model can help.[5]

The 'bio' part of the person-focused approach is safety netting. Here, the biological/psychiatric elements come in. This step should only have priority if there is a high risk of serious psychiatric disease (psychosis, endogenous depression) or if the psychosocial approach is not working. Withholding or postponing a psychiatric diagnosis is justified in most patients against the background of the low prevalence of serious psychiatric morbidity in primary care.[6]

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Lost Connections: Uncovering the Real Causes of Depression — and the Unexpected Solutions
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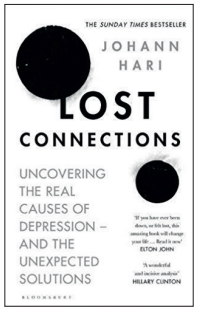

SEARCHING FOR DEPRESSION TREATMENTS

A teenage Johann Hari is prescribed paroxetine, an antidepressant, for the first time. Your depression, he is told by his GP, is a result of *'a chemical imbalance in the brain'* caused by *'depleted levels of a chemical named serotonin'*. Hari places the pill in his mouth. As the *'chemical kiss'* caresses his tongue and sinks to his stomach, Hari experiences:

'... a light thrumming I was sure consisted of my brain synapses groaning and creaking into the correct configuration ... I could do anything ... with my new chemical armor. I wasn't afraid.'

As the years went by, however, *'no matter how high a dose I jacked up my antidepressants to, the sadness would always outrun it'*. As his dosage increased from 20 mg to 60 mg over a period of a few years, Hari began to question the narrative he had been repeatedly told, that chemical antidepressants can defeat depression alone.

Undergoing a *'40 000-mile journey across the world'* in order to meet and conduct interviews with over 200 individuals, Hari collected the views of those battling depression — social scientists, psychiatrists, and medical experts in the fields of depression and anxiety — in order to outline *'nine proven causes of depression and anxiety'*, and offer *'seven social* [and] *psychological alternatives'* to use with chemical antidepressants.

Part memoir, part scientific and cultural study, *Lost Connections* is a deconstruction and examination of the narrative that has been told to millions — that antidepressants alone can cure depression. Hari argues that only in combination with tackling social and economic influences can depression be beaten with chemical support, and the evidence this book provides is impossible to ignore.

Though the uncomfortable facts, figures, and statistics relating to the mass-manufacturing and promotion of antidepressants provide fresh and disturbing insights into the individualistic, mass-consumerist nature of our capitalist society, *Lost Connections* is further strengthened as a result of Hari's seemingly effortless ability to weave stories. When Hari reports a meeting with an interviewee, for example, we are transported to the present tense. As a result, interviews are given new life by his narrative voice, and the scenes Hari creates can often conjure new and powerful images of their own. The result is a perfect balance of fictionalised non-fiction and factual evidence, coupling diverse personal narratives with an intense investigation into the failings of Western society to better connect us all.

Reflecting on *Lost Connections*, I strongly believe that what Hari has created may be one of the most important texts of recent years. The book gives a voice to those who cannot speak and hands them a megaphone to vibrate the monolithic towers of the antidepressant drug industries. It teaches that through community, through social and natural connection, and through understanding, depression can be tackled via alternative means.

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REFERENCES

1. NHS Digital. Antidepressants were the area with largest increase in prescription items in 2016. 2017. http://www.content.digital.nhs.uk/article/7756/Antidepressants-were-the-area-with-largest-increase-in-prescription-items-in-2016 (accessed 3 May 2018).
2. Reeve J, Cooper L, Harrington S, *et al.* Developing, delivering and evaluating primary mental health care: the co-production of a new complex intervention. *BMC Health Serv Res* 2016; **16:** 470.
3. Toombs SK. *The meaning of illness. A phenomenological account of the different perspectives of physician and patient.* Dordrecht: Kluwer Academic Publishers, 1993.
4. Lynch JM, Askew DA, Mitchell GK, Hegarty KL. Beyond symptoms: defining primary care mental health clinical assessment priorities, content and process. *Soc Sci Med* 2012; **74(2):** 143–149.
5. Rapp CA, Goscha RJ. *The Strengths model.* Oxford: Oxford University Press, 2011.
6. Van de Lisdonk EH, van den Bosch WJHM, Lagro-Janssen ALM, Schers HJ. *Ziekten in de huisartspraktijk [Morbidity in general practice].* Maarssen: Elsevier Gezondheidszorg, 2008.